RECEIPT FOR CARE

Payment received: $ **Date:**

PROVIDER INFORMATION

Provider/business name

Street address

City State Zipcode

Phone number

CLIENT INFORMATION

Parent's name

Child name Age

Child name Age

Child name Age

SERVICE DETAIL

Service description

Service Rate ◯ Per hour ◯ Per day

SERVICE DATE	HOURS (IF APPLY)		RATE	SUBTOTAL
	From	To		
			$	$
			$	$
			$	$

TOTAL $

I certify that the above is true. I have provided the services and received the payment from my client.

Provider signature **Date**